Care service inspection report

St. Francis Nursing Home

Care Home Service Adults

54 Merryland Street
Glasgow
G51 2QD
Telephone: 0141 445 1118

Inspected by: Joy Fleming

Elaine MacLean, Professional Adviser Palliative Care
Marjory Thompson, Professional Adviser Nutrition

Type of inspection: Unannounced

Inspection completed on: 30 August 2012

Contents

Service provided by:

Franciscan Sisters Monoresses

Service provider number:

SP2003002371

Care service number:

CS2003010480

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Summary

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change after this inspection following other regulatory activity. For example, if we have to take enforcement action to make the service improve, or if we investigate and agree with a complaint someone makes about the service.

We gave the service these grades

Quality of Care and Support	2	Weak
Quality of Environment	2	Weak
Quality of Staffing	2	Weak
Quality of Management and Leadership	2	Weak

What the service does well

We received some very positive feedback from residents and relatives. We saw some positive interactions between staff and residents. It was clear that some people were appreciative of the care and support they received. The spiritual needs of people living in the home were clearly given most consideration. We saw that this provided continuity and comfort to residents and relatives.
We felt that the manager and Board members we met were very committed to improving the service.

What the service could do better

There were a number of areas in which the provider needed to make improvements. We felt that immediate priority needed to be given to how people were supported with eating and drinking and to ongoing staffing issues within the home.
We have noted these within Quality Theme 1, Statement 3 and Quality Theme 2, Statement 2 in this report.
We also felt that the provider needed to review the overall management structure and related procedures to make sure that roles and responsibilities were clearly identified for all. We felt that this was necessary to make sure that the service could be provided and monitored appropriately overall.

What the service has done since the last inspection

We felt that the new manager who started in January 2012 demonstrated a very caring approach and was very committed to improving the service.

Conclusion

Overall whilst we received some very positive feedback, we also identified some serious gaps in service provision.
When we discussed our findings with the manager and some two Board members, we felt they were very committed to making the necessary changes.
We have made a number of requirements and this has impacted on the grades as detailed in this report.

Who did this inspection

Joy Fleming
Elaine MacLean, Professional Adviser Palliative Care
Marjory Thompson, Professional Adviser Nutrition

1 About the service we inspected

The care home is owned and run by the Order of Franciscan Sisters Minoress. It was registered with the Care Commission in April 2002. This registration transferred to the Care Inspectorate in April 2011.

The care home is a purpose built two storey building. All residents have a single room with en-suite bathroom facilities. There are a number of communal areas including a lounge and quiet room on each floor.
There is a chapel at the front of the care home.

The care home aims to:

"respond to the desires and aspirations of the residents recognition of their dignity and their desire of being respected."

It is managed within the context of the Roman Catholic faith which underpins the life of the home.

Based on the findings of this inspection this service has been awarded the following grades:

Quality of Care and Support - Grade 2 - Weak
Quality of Environment - Grade 2 - Weak
Quality of Staffing - Grade 2 - Weak
Quality of Management and Leadership - Grade 2 - Weak

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Grades for this care service may change following other regulatory activity. You can find the most up-to-date grades for this service by visiting our website www.careinspectorate.com or by calling us on 0845 600 9527 or visiting one of our offices.

2 How we inspected this service

The level of inspection we carried out

In this service we carried out a medium intensity inspection. We carry out these inspections where we have assessed the service may need a more intense inspection.

What we did during the inspection

Joy Fleming, Inspector carried out an unannounced visit to the care home during the day shift on 12th July and an announced visit on the 13th July 2012.

Elaine MacLean, Professional Adviser for Palliative Care accompanied Joy Fleming on a third visit to the home on Tuesday 24th July 2012.

Marjorie Thompson, Professional Adviser for Nutrition was involved in providing feedback on a range of documents between the visits to the home.

A meeting was held with the manager, two Board members and the Local Authority Contract Monitoring Officer at the home on 30th August to discuss the findings of the inspection.

Prior to the inspection, we received several Care Inspectorate Questionnaires (CSQs) from residents and relatives/carers.

During the inspection visits we talked with some residents and relatives.

We also had a look at the environment and observed staff practice and residents' experiences.

We talked with the Manager and some staff on shift.

We also looked at a range of records relating to service provision and resident's care and support including some policies, personal plans, accident and incident reports and some minutes of residents' and staff meetings.

We took all of the above into account when we wrote this report.

Grading the service against quality themes and statements

We inspect and grade elements of care that we call 'quality themes'. For example, one of the quality themes we might look at is 'Quality of care and support'. Under each quality theme are 'quality statements' which describe what a service should be doing well for that theme. We grade how the service performs against the quality themes and statements.

Details of what we found are in Section 3: The inspection

Inspection Focus Areas (IFAs)

In any year we may decide on specific aspects of care to focus on during our inspections. These are extra checks we make on top of all the normal ones we make during inspection. We do this to gather information about the quality of these aspects of care on a national basis. Where we have examined an inspection focus area we will clearly identify it under the relevant quality statement.

Fire safety issues

We do not regulate fire safety. Local fire and rescue services are responsible for checking services. However, where significant fire safety issues become apparent, we will alert the relevant fire and rescue services so they may consider what action to take. You can find out more about care services' responsibilities for fire safety at www.firelawscotland.org

The annual return

Every year all care services must complete an 'annual return' form to make sure the information we hold is up to date. We also use annual returns to decide how we will inspect the service.

Annual Return Received: Yes - Electronic

Comments on Self Assessment

Every year all care services must complete a 'self assessment' form telling us how their service is performing. We check to make sure this assessment is accurate.

The service returned their self assessment.

Taking the views of people using the care service into account

We have included the views of people using the service throughout the report.

Taking carers' views into account

We have included the views of carers throughout the report.

3 The inspection

We looked at how the service performs against the following quality themes and statements. Here are the details of what we found.

Quality Theme 1: Quality of Care and Support

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service.

Service strengths

We felt that the manager was very caring and very committed to involving residents and relatives in improving the service.

We saw that a survey had been carried out with relatives, residents and visiting professionals.
We saw that some very positive comments had been made by people who had completed the survey.

There was a suggestion box in the front hall.

Newsletters were produced and distributed.

We saw that relative and residents' meetings were held and minutes of these were available.

We saw some records which showed us that when some people had made some suggestions or raised an issue that they had been responded to.

Areas for improvement

We found several records which showed us that various concerns and suggestions had been raised in various ways over time and we could not see what action had been taken in response.

Further to this, we were unable to see that there was a clear and accountable way of logging complaints and recording what action was taken when issues were raised.
We saw that there had been a number of issues raised about different areas of service provision.
A complaints log needs to be introduced. (See Requirement 1).

One person indicated that they did not know that they could make a complaint to the Care Inspectorate and two people said they did not know about the care home's complaints procedure.

Some people indicated that their relative did not have a personal plan.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 1

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 1, Statement 1:
   The provider needs to produce an adequate complaints procedure and to keep a complaints log which will evidence that all complaints are responded to appropriately.

   This is in order to comply with SSI Regulation 25 Complaints.
   Timescale: Immediately on receipt of this report.

Statement 3

We ensure that service users' health and wellbeing needs are met.

Service strengths

We felt that the manager demonstrated a very caring approach and we felt that she had a very positive commitment to making sure that needs were met in a person centred way.

Some people told us that they were very appreciative of the care and support and very happy that their relative had a place in the home.

"St. Francis is a 5 star nursing home and staff are 100% genuine O.K. by me."

"Overall, very happy with nursing care and trust the staff to look after her with dignity."

"My relative is always safe, clean, well cared for.....I think the Home is always improving, I've been impressed with the new manager since she started in January."

"St. Francis care home has not only given my relative excellent care also, it welcomes our family. They are always willing to take the time to talk to us and we feel our relative's needs are always considered. What a beautiful home, clean and rich in warmth towards us all."

"I am very grateful that she has come to live in a place where she is loved and cared for so well."

"My relative is very well cared for and I am treated nicely when I visit."

"No serious complaints have arisen and any minor ones (food) have been dealt with very quickly and to our satisfaction."

There is a chapel within the care home. Mass is celebrated four times a week. It was clear that the meeting of spiritual needs within the context of the Roman Catholic faith underpinned the life of the home.

Some staff we met were friendly and caring.

There was an activities co-ordinator who demonstrated enthusiasm and a good level of knowledge of individual residents and local resources.
We saw a range of information on display such as a timetable of activities.
Some people were enjoying some activities during our visits for example, Music and Movement in the upstairs lounge.

Photographs were on display which showed that some residents had enjoyed a number of activities and outings, for example an outing which had been held to Blair Drummond on 1st June 2012.
Daily newspapers were available in quiet lounges.

A group involving residents and staff had been set up to discuss activities and minutes of these were available.

We were told about the new role of floor manager, where a staff nurse in each unit was managing the unit. The aim of this was to improve the monitoring of care and support and make sure that roles and responsibilities of all staff were clearer.
We were told that key workers were being given more responsibilities.

The manager told us that a medication review was carried out by an external NHS pharmacy team and that the last one had taken place last month.

We saw that there was a computer system in place which was used to record all assessments and care planning.
When we looked at a sample of care plans and related records, we saw that people were receiving a range of support for example, from external professionals such as GPs, Community Psychiatric Nurse and dietitian.

The Professional Adviser on Palliative Care visited the home and found the following:

For residents who require care towards the end of their life, the Liverpool Care Pathway for end of life care documentation was implemented in the service in 2011 by the Liverpool Care Pathway Champions in the home.

We were told that there were two palliative care champions for this end of life care documentation in the service. Local hospice staff also came to the home to provide palliative care education and training to staff.

Education on the McKinley syringe pump was provided by staff from the local nursing home liaison team.

The service's senior staff had knowledge of the emergency palliative care summaries completed by GPs, which assists in communicating residents anticipatory care needs. There were four local GP practices who supported residents within the care home.

Areas for improvement

In the CSQs we received, two people indicated they did not know about personal plans.

We found that because all personal plans and related records were kept on a computerised system that this created some issues in relation to how staff were keeping records.
After looking at a sample of care plans, we felt that they did not provide adequate detail about individual resident's needs and how these were being met. We were particularly concerned that when serious health needs were identified such as risk of weight loss and malnourishment that there was no clear information available about what staff were doing to make sure that the right care and support was in place.
We have made a requirement about this. (Please see Requirement 1).

In the CSQs we received, one person strongly disagreed that the service provided the type of food that their relative likes, taking account of any specialised dietary needs.
Two people did not know if there were always snacks and hot and cold drinks available.
One person did not know and another person disagreed that the meals were nutritious.
One person said the food was "so so". We saw someone bringing fresh fruit in for their relative.

In records, including surveys, we saw that relatives and staff had made repeated comments over time raising concern about the quality of the food and in particular the amount of processed food.
We saw that some people had asked for more information on what was on the menu and to know exactly what their relative was eating.
During our visits, we saw that some people looked very frail and thin. We also observed some mealtimes.
We were unable to clearly see that all residents received the type of food they needed or that they got the help they needed to eat and drink. We were also concerned about the lack of variety and the quality of food that was served. We felt that the mealtime experience in the dining room upstairs was not as relaxed as we would have expected.
When we looked at some records, we were very concerned to see that some people had been losing weight and we could not clearly see what action staff had taken over time. For example, we could not see that any food charts were in place and therefore there was no way of monitoring what someone was eating over time.

Whilst we saw records which showed that weight loss had been identified, we could not see that appropriate action had been taken as a result. We found that not everyone at risk had had their weight taken at appropriate points.

We saw that where referrals had been made to the dietitian there was no record of any follow up. Also we saw that a dietitian had visited and given detailed guidance to staff however, we could not see that staff had been following this.

Given our concern about this, we sought advice from the Care Inspectorate Professional Adviser for nutrition. She looked in detail at a range of information and found a number of serious issues.

The service level agreement with the catering provider did not reflect best practice. There was no indication that the authors fully understood the eating, drinking and dietary needs of older people. We would expect that there would be an awareness of the need to carry out a resident population needs assessment prior to menu planning including those who are nutritionally well and nutritionally vulnerable and this had not been done.

The audit showed that a high proportion of residents would be categorised as nutritionally vulnerable at admission and currently.
The results of the nutritional audit indicated that the food provision has not been meeting the residents' needs.
We felt that the menu needed to be improved for example,

*it appeared that the menu was not planned to meet any specific food or nutritional standards. We felt that the service needed to understand and implement these standards.
*Most of the residents were nutritionally vulnerable and the menu did not reflect that.
*For individuals to achieve 5 fruit and vegetables a day there needed to be at least 9 on the menu to accommodate preferences and for these to be promoted throughout the day
*We found that a high number of residents were on medication for constipation.
*Alternatives were not always available, for example lunch soup
*There were a lot of chips or similar and a lot of processed food at supper.
*There was a lack of information available on the menu such as the type of cereals and bread at breakfast time.

The menu also did not include specific information on how soft easily chewed, mashed and pureed diets would be catered for at snacks.
A full alternative menu was needed, as was full information on what was available during out of hours service. We also needed to see that full information on which fluids were provided and also full information on how special diets were catered for, such as fortified and food textured diets.

We have made a requirement about this. (See Requirement 2 below).

When we looked at some policy documents including the Nutrition policy, the policy on dietary and fluid intake and the Aramark Healthcare nutritional policy for St. Francis Nursing Home, we found that they needed to be completely reviewed to reflect best practice including policy guidance available on the Care Inspectorate website.

We have made a requirement about this. (See Requirement 3 below).

We saw that there was an inconsistent approach as to how staff responded when someone was showing behaviour which challenges. In one case, we saw that psychotropic drugs were given and that the dose had been increased. When we looked at records and talked with staff, we could not clearly see why this had happened. We were concerned that we could not see that other ways of supporting the person had been tried prior to commencing administration of the medication. We felt that this did not reflect good practice.
We have made a requirement about this. (See Requirement 4 below).

We could not see that pain assessments were carried out and that pain relief was reviewed.
We raised this with the manager and asked that this was looked at. We will look at the progress on this at the next inspection visit.

The Professional Adviser on Palliative Care carried out a visit to the home and found the following:

Many policies within the service needed to be reviewed, updated, ratified by the Board of Managers and implemented in the service. We felt that the provider needed to prioritise the policy review.

The policies in the care home relating to palliative and end of life care, required to be reviewed e.g., the palliative care policy was dated 2007 and needed to be updated to include current best practice. (See Requirement 5 below).

There were a number of residents in the service who had cognitive decline. Very few residents had an appropriate assessment, with a certificate of incapacity in place and a treatment plan. We felt that the staff in the service needed to work closely with their GP practices, the residents themselves and their relatives or welfare guardians to discuss putting these assessments for certificates in place where this is required. (See Requirement 6 below).

We also felt that the provider should consider providing education and training to all staff on anticipatory care planning in their educational training plan for the next year. We also felt that the provider needed to make sure that staff in the care home had the most up to date best practice information available.

There were limited resources for activities. The co-ordinator had no dedicated room to work or store resources in. She showed us a space upstairs which had limited resources. We were told that the receptionist was on leave. We saw that the activities co-ordinator sat at the reception in the main hallway. In effect, we saw that she spent time answering the telephone and the door. We felt that this detracted from the provision of activities.
We were told that the receptionist was returning to work and that there were plans to have an increased focus on activities. We will look at the progress on this on our next visit.

We felt that staff needed training in a number of areas related to their role in health and wellbeing.
We have referred to this also in Quality Theme 3, Statement 3.

Grade awarded for this statement: 2 - Weak

Number of requirements: 6

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 1, Statement 3:
   The provider needs to review and improve the way in which care planning is carried out .
   This includes the need to make sure that all relevant records are in place in relation to all identified health care needs such as assessments, care plans and specific records such as food and fluid charts as appropriate.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users and Regulation 5(1) personal plans.
   Timescale : to begin immediately on receipt of this report.

2. Requirement with reference to Theme 1, Statement 3:
   The provider must review and implement changes to the menu to ensure it meets the dietary needs of residents and use best practice standards to help them plan. Food in Hospitals national catering and nutrition specification for food and fluid provision in hospitals in Scotland 2008 Scottish Government
   Download from www.scotland.gov.uk/Publications/2008/06/ 24145312/0 which is applicable to care homes.

   The provider must review and implement changes to the provision of special diets, in particular high calorie diets and modified food textured diets, to ensure residents receive a balanced and nutritious diet which is appropriate to their individual needs.

   Service must have choice and should be properly consulted at the menus development stage and on an ongoing basis.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users and Regulation 5(1) personal plans.
   Timescale : to begin immediately on of receipt of this report.
3. Requirement with reference to Theme 1, Statement 3:
   The Provider shall undertake a review of their Food and Nutrition Policy and Procedures to ensure that service user's food, fluid and nutritional care is supported by clear management arrangements covering all the relevant food, fluid and nutritional care topics.
   The provider shall provide operational procedures to staff to ensure best practice is applied including but not limited to management of unplanned weight loss, modified food textured diets, hydration and menu planning.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users.
   Timescale : to begin immediately on of receipt of this report.
4. Requirement with reference to Theme 1, Statement 3:
   The provider should review and improve the policy and procedures in place in relation to how people who display behaviour which challenges are cared for and supported.

   This is in order to comply with Regulation 4 (1)(a). A provider must make proper provision for the health, welfare and safety of service users
   Timescale: within two months of receipt of this report.

5. Requirement with reference to Theme 1, Statement 3:
   The provider must ensure that all policies in the service relating to palliative and end of life care are reviewed and updated to include current best practice.

   This is to comply with Regulation 4 (1)(a) A provider must make proper provision for the health, welfare and safety of service users.

   In making this requirement, the National Care Standard for older people Management and staffing arrangements Standard 5 and Making good care better Practice Statement 1.2 have been taken into account
   Timescale: within 3 months on receipt of this report
6. Requirement with reference to Theme 1, Statement 3:
   The provider should ensure that the home liaises with local GP practices, the residents themselves and their relatives/welfare guardians to discuss putting any necessary assessments for capacity in place; following this issue certificate of incapacity and treatment plans where it is found to be necessary.

   This is to comply with Regulation 4 (1)(a) A provider must make proper provision for the health, welfare and safety of service users.

   In making this requirement, the National Care Standard for older people Keeping well - healthcare Standard 14.3 and Making choices Standard 8 and these have been taken into account.
   Timescale: within 1 month on receipt of this report

Quality Theme 2: Quality of Environment

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the environment within the service.

Service strengths

Please see Quality Theme 1, Statement 1.

Areas for improvement

Please see Quality Theme 1, Statement 1.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 2

We make sure that the environment is safe and service users are protected.

Service strengths

We received some positive feedback from people living in the care home and relatives and it was clear that some people were happy with the environment.

When we visited the home we found that it was generally clean and tidy.

We saw that the tea points had been refurbished on each floor.

We saw records which showed that service checks had been carried out on hoists, mattresses and slings.

Areas for improvement

We were concerned to find that concerns and allegations had been raised over a significant period of time about staff practices. We were unable to see that appropriate and adequate action had been taken when these were raised.

We investigated and upheld a complaint about allegations made about abuse. We made two requirements in relation to this prior to this inspection and we were concerned that we could not see that clear systems had been put in place to address the requirements we made.
We have repeated the requirements in this report. (See requirements 1 and 2 below).

We were unable to see clear records about accidents and incidents.
For example, we saw records which indicated that someone had unexplained bruising. When we talked with staff and looked at related records we could not find clear information about this and what action staff had taken to investigate and address this.
We also saw records about people having recurrent falls and we could not see what action had been taken to try and prevent further falls happening.
We have made a requirement about this. (See requirement 3 below).

We saw that an independently contracted person visited the home on a regular basis and had access to the entire computer system including personal records. We queried their role and responsibilities in doing so. We also asked the provider to review whether a PVG check had been carried out.

We saw repeated reference to the two bathrooms being refurbished. For example, we saw this mentioned in Newsletters between May 2009 and the most recent newsletter. However, we were unable to see what progress had been made about this.

We saw clean linen being stored on a trolley in the bathroom which is contrary to good infection control practice.

When we looked at a sample of maintenance records, we saw that a warning notice had been issued about the gas cooker in the main kitchen. When we asked about this, we were told that this did not constitute a direct risk to health and safety and that it related to the age of the cooker.

We saw records which showed that the seals were broken on the fridge in the main kitchen.
When we asked about this the administrator looked into this and advised us via e-mail on 17/7/12 that the manufacturer was no longer in business, the needed parts could not be obtained and therefore a quote for the replacement of the fridge had been requested.

There was no inventory of aids and equipment. It was therefore difficult to evidence that adequate checks were taking place for example, of bedrails, hoists and slings.

We saw records which showed that some staff felt that they could do with one more staff member on shift in the mornings. In a staff survey, some staff had noted that they did not feel they had enough time to spend with individual residents.
We were told that some activities were cancelled due to lack of staff for example, an outing to a line dancing class.

Grade awarded for this statement: 2 - Weak

Number of requirements: 3

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 2, Statement 2:
   The service provider must ensure that all incidents involving the abuse of a vulnerable adult is managed as per The Adult Support and Protection (Scotland) Act 2007 and best practice guidance.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users
   Timescale - Within 24 hours of receipt of this report.
2. Requirement with reference to Theme 2, Statement 2:
   The service must notify the Care Inspectorate of all allegations of abuse (as defined in adult support and protection legislation).

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users
   Timescale - Within 24 hours of receipt of this report.

3. Requirement with reference to Theme 2, Statement 2:
   The provider must review and improve the way that accidents and incidents are monitored and responded to.

   This is in order to comply with SSI 210/2011: Regulation 4 (1) welfare of service users.
   Timescale: one month of receipt of this report.

Quality Theme 3: Quality of Staffing

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.

Service Strengths

Please see Quality Theme 1, Statement 1.

Areas for improvement

Please see Quality Theme 1, Statement 1.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 2

We are confident that our staff have been recruited, and inducted, in a safe and robust manner to protect service users and staff.

Service strengths

We saw that the provider had a range of policies and procedures in place.
We sampled some personal files and found that there were some relevant records in place.

Areas for improvement

We had serious concerns about the robustness of the recruitment procedures which were in place.
We saw an example of a written reference which had no evidence of authority. We found that references were not followed up to verify who had written them.
Adequate checks were not carried out according to professional registers such as the Nursing and Midwifery Council (NMC).

We have made a requirement about this. (See Requirement 1 below).

Grade awarded for this statement: 2 - Weak

Number of requirements: 1

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 3, Statement 2:
   The provider must review and improve the way in which recruitment is carried out.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users
   Timescale: to begin immediately on receipt of this report.

Statement 3

We have a professional, trained and motivated workforce which operates to National Care Standards, legislation and best practice.

Service strengths

We received some very positive feedback from residents and relatives.
We felt that there was a positive commitment to making sure that staff received the training they needed.

There were records showing that staff had had training in a range of relevant topics including team building Diabetes, Protection of Vulnerable Adults, Effective communication, Moving and Handling and Dementia care.

We saw that some staff were very attentive and caring in their approach with residents.
When we talked with staff we felt that they were knowledgeable about individual needs and wishes.

Areas for improvement

At the time of our inspection there were ongoing issues affecting teamwork across the entire staff team.

We saw that an external Human Resource person had become involved however, we were unable to clearly see what action had been taken by them.

Issues had also been raised over time about the practice of some individual staff members.We were unable to see what action had been taken in relation to these matters. For example, we saw that some allegations had not been investigated.
We have also referred to this in Quality Theme 2, Statement 2.

We were concerned that there had been some blurring of roles and responsibilities and also in relation to how some staff relationships had developed.
We have also referred to this in Quality Theme 4, Statement 4.

In relation to nutrition we identified the need for catering and care and nursing staff to have updated training, with regard to their roles and responsibilities and that this was carried out in line with best practice guidance.
Given our concerns about nutrition we have made a specific requirement about this. (Please see Requirement 1 below)**.**

Overall, when we looked at training records we felt that there were a number of gaps. For example, records indicated that several staff had not done training in food hygiene, infection control, personal care, nutrition and skin care.

We also felt that where training had been carried out, that refresher training had not been carried out for a significant period of time such as skin care.
We could not see that ongoing evaluation was carried out about the impact of training on staff practice and resident experience and outcomes.
We have made a requirement about this. (See Requirement 2 below).

We checked the NMC register in relation to the 10 named Staff Nurses working at the home. Of these, one was noted as "not practising" and we could not see that another Staff Nurse was registered. We have asked the provider to address this and we will look at the progress on this on the next inspection visit.

The manager told us she was working on the introduction of regular planned supervision. The aim was that staff would receive supervision 4 times a year and that it was to be initiated by the end of the year.

We saw that in the staff surveys, staff had raised issues and suggestions such as the need for clarification of carers jobs and we could not see how these had been responded to.

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 3, Statement 3:
   The provider shall ensure that the person responsible for planning the menu undertakes training and has a demonstrable understanding of menu planning to meet the needs of older people and that this is reflected in menu planning.
   All care and nursing staff involved in the direct provision of care and support must be aware of best practice and their roles and responsibilities in relation to this.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users.
   Timescale: to begin immediately on of receipt of this report.
2. Requirement with reference to Theme 3, Statement 3:
   The provider must carry out a training analysis of all care home staff and produce a training plan for the staff team.
   The provider must ensure that ongoing evaluation of the impact of staff training takes place.

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users and Regulation .
   Timescale: two months of receipt of this report.

Quality Theme 4: Quality of Management and Leadership

Grade awarded for this theme: 2 - Weak

Statement 1

We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service.

Service strengths

Please see Quality Theme 1, Statement 1.

Areas for improvement

Please see Quality Theme 1, Statement 1.

Grade awarded for this statement: 3 - Adequate

Number of requirements: 0

Number of recommendations: 0

Statement 4

We use quality assurance systems and processes which involve service users, carers, staff and stakeholders to assess the quality of service we provide.

Service strengths

We felt that the manager and Board members we met had a positive commitment to developing ways of carrying out quality assurance.
In the self assessment it had been identified that there was a need to introduce more ways of measuring the quality of the service.

Records showed us that when some issues were raised that they addressed and that action was taken.

We were told that a Human Resource person was involved in developing ways of improving the way the home was managed and addressing some issues which had been identified.

Staff told us about the introduction of a floor manager on each floor, which was designed to help improve service provision and the way in which staff were working.

We saw that there had been some surveys carried out with residents, relatives and some visiting professionals. Some of the feedback in these was very positive.

We were told that the Board of Management held monthly meetings and we saw some minutes of these meetings.

The manager told us that a Medication Audit had been bought in disc form.

Areas for improvement

We felt that the provider needed to make sure that the management and staffing structure were reviewed. We were concerned at the lack of clarity in relation to roles and responsibilities of those involved with the running, management and direct provision of the service.

The minutes we saw of the Voluntary Management Board meetings were limited in content and did not reflect discussion about areas of development or improvements, which were planned or to be made over time.

There was no depute manager in place. By the time of our last meeting with the provider we were told that this was being reviewed.

A new role of floor manager on each floor had recently been introduced to help with staffing issues. We could not see how the progress on this was being monitored.

A HR person had been involved in relation to a number of staffing issues. However, it transpired that this was on a voluntary basis and we could not see clear records about the impact of this on outcomes.

We found records which showed us that a number of different concerns and issues had been raised by relatives and residents over time. We were very concerned that we could not find clear consistent and accountable information to show that they had been addressed adequately according to best practice guidance, standards and legislation.

Further to this, we were concerned to find a number of serious issues and gaps relating to service provision which had not been identified and addressed. We have noted these in Quality Theme 1, Statement 3 and Quality Theme 2, Statement 2.

We had specific concerned about the service provision in relation to eating and drinking and nutritional care.
We have made a specific requirement about this. (See Requirement 2 below).

Policies did not reflect best practice guidance and they were not dated or authority noted.

We were shown that there was an auditing and monitoring facility built into the computerised system in place. However, this was not being used.

Notifications were not sent to the Care Inspectorate (CI) as per guidance available on the CI website.
(See Requirement 1 below).

We found that the on call procedures needed reviewed. Staff nurses who were on duty and involved in direct
care and support were noted as being on call or were on days off. When we made a telephone call to the home between inspection visits, the person answering was unclear about who was on shift and when.
Contingency plans need to be in place for anticipated and emergency cover.

Grade awarded for this statement: 2 - Weak

Number of requirements: 2

Number of recommendations: 0

Requirements

1. Requirement with reference to Theme 4, Statement 4:
   The provider must make sure that notifications are submitted to the Care Inspectorate (CI) according to the latest guidance available on the CI website.

   This is in order to comply with SSI 210/2011: Regulation 21 Notification of Death, Illness and Other Events.
   Timescale: with immediate effect on receipt of this report.
2. Requirement with reference to Theme 4, Statement 4:
   The provider shall ensure it can demonstrate it has an overview of how well it is managing residents' eating, drinking and nutritional care

   This is in order to comply with SSI 210/2011: Regulation 4(1) welfare of service users.
   Timescale :one month on of receipt of this report.

4 Other information

Complaints

We have repeated the requirements made following the complaint investigation.

Enforcements

We have taken no enforcement action against this care service since the last inspection.

Additional Information

N/A.

Action Plan

Failure to submit an appropriate action plan within the required timescale, including any agreed extension, where requirements and recommendations have been made, will result in SCSWIS re-grading the Quality Statement within the Management and Leadership Theme as unsatisfactory (1). This will result in the Quality Theme for Management and Leadership being re-graded as Unsatisfactory (1).

5 Summary of grades

Quality of Care and Support - 2 - Weak	
Statement 1	3 - Adequate
Statement 3	2 - Weak
Quality of Environment - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	2 - Weak
Quality of Staffing - 2 - Weak	
Statement 1	3 - Adequate
Statement 2	2 - Weak
Statement 3	2 - Weak
Quality of Management and Leadership - 2 - Weak	
Statement 1	3 - Adequate
Statement 4	2 - Weak

6 Inspection and grading history

Date	Type	Gradings	
13 Dec 2010	Unannounced	Care and support Environment Staffing Management and Leadership	5 - Very Good Not Assessed Not Assessed Not Assessed
5 Jul 2010	Announced	Care and support Environment Staffing Management and Leadership	5 - Very Good Not Assessed 5 - Very Good Not Assessed
28 Jan 2010	Unannounced	Care and support Environment Staffing	5 - Very Good 5 - Very Good Not Assessed

		Management and Leadership	Not Assessed
9 Sep 2009	Announced	Care and support Environment Staffing Management and Leadership	5 - Very Good 5 - Very Good 5 - Very Good 5 - Very Good
16 Jan 2009	Unannounced	Care and support Environment Staffing Management and Leadership	4 - Good Not Assessed 4 - Good Not Assessed
29 Jun 2008	Announced	Care and support Environment Staffing Management and Leadership	4 - Good 4 - Good 4 - Good 4 - Good

All inspections and grades before 1 April 2011 are those reported by the former regulator of care services, the Care Commission.

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ی ہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے-

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